



PROVIDER APPLICATION Family Care Partnership Services

INSTRUCTIONS: Independent Care Health Plan (“iCare”) may be awarded a Partnership Program Contract (<http://dhs.wisconsin.gov/wipartnership>) by the State of Wisconsin, Department of Health Services and is soliciting providers who are interested in participating in the Independent Care provider network. The iCare application process is guided by the following values:

- a) Offering the broadest range of choices to prospective consumers
- b) Recognizing the need for continuity of care wherever possible
- c) Ensuring the availability of credentialed and licensed providers as required
- d) Rewarding cost and service efficiencies

All interested providers will be considered for iCare network participation and a contractual relationship. Providers will note that contracted participation in the iCare network will not include a guarantee of utilization or exclusivity. Responding providers are requested to return this form by mail (iCare, 1555 RiverCenter Drive, Suite 206, Milwaukee, WI 53212), fax (414-231-1092) or email (netdev@icare-wi.org) prior to the submission deadline:

May 15, 2009

Type or print your information on this application. If a question does not apply to your application, please write "N/A" in the field. Read instructions for information detail. Include copies of supporting documentation.

SECTION I: Organizational Information

Write "N/A" if not applicable.

Provider Legal Name:		Federal TIN or SSN:		Provider NPI Number:	
Provider Street Address:		Provider Medicaid Number:		Provider Medicare Number:	
Provider City Address:		State:	ZIP:	Handicapped Accessible: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Provider Phone Number:		Provider Fax Number:		ROI Fax Number:	
Contact Name:	Contact Title:	Contact Phone:		Contact Email:	
Signor Name:	Signor Title:	Signor Phone:		Signor Email:	
Billing Name:	Billing Title:	Billing Phone:		Billing Email:	
Billing Address:	Billing City:	Billing State:	ZIP:	Billing Fax:	
Counties Served: <input type="checkbox"/> Milwaukee <input type="checkbox"/> Waukesha <input type="checkbox"/> Racine		<input type="checkbox"/> Kenosha <input type="checkbox"/> Washington <input type="checkbox"/> Ozaukee <input type="checkbox"/> Sheboygan		Population Served: <input type="checkbox"/> Frail Elderly <input type="checkbox"/> Physical Disabilities <input type="checkbox"/> Mental Illness <input type="checkbox"/> AODA <input type="checkbox"/> Developmental Disabilities	
Respondent currently holds a service contract with a Wisconsin Family Care or Family Care Partnership Program. <input type="checkbox"/> Yes <input type="checkbox"/> No					



Section II: Service Location Information

Write "N/A" if not applicable. Add other locations on a separate sheet if needed with the same information provided.

Referral Contact Name:		Referral Contact Phone:		Referral Contact Email:	
Primary Service Location Name:				Hours of Operation:	
Address (Street):		City:		State:	ZIP:
Phone:	Fax:		Duns:		
Secondary Service Location Name:				Hours of Operation:	
Address (Street):		City:		State:	ZIP:
Phone:	Fax:		Duns:		
Secondary Service Location Name:				Hours of Operation:	
Address (Street):		City:		State:	ZIP:
Phone:	Fax:		Duns:		

Section III: Family Care Partnership Services Provided

Provide general information on the featured categories of service that you or your organization provides. Check the services you offer. Leave unchecked rows blank:

Partnership Service Category	Credential	Documentation
<input type="checkbox"/> Adaptive Aids	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Adult Day Care	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> AODA Day Treatment	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> AODA Other (Non-Physician)	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Chiropractor	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Communication Aids/Interpreter Services	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Community Support Program	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:



<input type="checkbox"/> Consumer Education & Training	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Counseling & Therapeutic Resources	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Crisis Intervention	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Daily Living Skills Training	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Day Services/Treatment	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Dentistry	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Durable Medical Equipment	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Home Health	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Home Modifications	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Housing Counseling	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Meals: Home Delivered	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Medical Supplies	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Mental Health Day Treatment	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Mental Health Services (non-physician)	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Nursing Facility (ICF/MR, IMD)	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Inpatient Services (non-IMD 21-65)	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Nursing Services <input type="checkbox"/> Respiratory Care <input type="checkbox"/> Intermittent <input type="checkbox"/> Private duty	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Personal Care	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Emergency Response Services	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Prevocational Services	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Prosthetics	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:



Partnership Service Category	Credential	Documentation
<input type="checkbox"/> Relocation Services	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Residential Services <input type="checkbox"/> RCAC <input type="checkbox"/> CBRF <input type="checkbox"/> Adult Family Home <input type="checkbox"/> Children's Foster Care <input type="checkbox"/> Treatment Foster Care	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Respite Care <input type="checkbox"/> Institutional <input type="checkbox"/> Non-institutional	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Specialized Medical Equipment/Supplies	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Supportive Employment	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Supportive Home Care	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Therapy (Non-Hospital) <input type="checkbox"/> Occupational <input type="checkbox"/> Physical <input type="checkbox"/> Speech & Language	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Transportation (non-emergency)	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Vehicle Modifications	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:
<input type="checkbox"/> Vocational Futures Planning	Certified/Licensed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Name Certifications/Licenses:

Section IV: Rates & Units of Services

For each of the service categories checked above, provide a detailed list of service elements, their rates, and unit definitions. Use additional pages as necessary, providing the same information. Leave unneeded service categories blank.

Family Care Partnership Service Category:		
Service Component Name/Category:	Rate/Unit of Service:	Unit of Service Definition:
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____
4. _____	4. _____	4. _____
5. _____	5. _____	5. _____



Family Care Partnership Service Category :		
Service Component Name/Category:	Rate/Unit of Service:	Unit of Service Definition:
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____
4. _____	4. _____	4. _____
5. _____	5. _____	5. _____
Family Care Partnership Service Category :		
Service Component Name/Category:	Rate/Unit of Service:	Unit of Service Definition:
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____
4. _____	4. _____	4. _____
5. _____	5. _____	5. _____
Family Care Partnership Service Category :		
Service Component Name/Category:	Rate/Unit of Service:	Unit of Service Definition:
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____
4. _____	4. _____	4. _____
5. _____	5. _____	5. _____

Section IV: Assurances

By signing this Application, the respondent confirms that it (he/she) understands and assures the following:

- a) The Signor below is authorized to represent the provider in this Application.
- b) This Application is not a contract for the utilization or provision of waiver services.
- c) The information provided in this Application is accurate, truthful and current.
- d) The Provider wishes to receive a service contract that reflects mutual consent between the parties.
- e) The rates for services proposed in this Application are not higher than the Provider currently charges any other Wisconsin Family Care or Family Care Partnership Program.

Authorized signature & title:	Date:
Print signature & title:	

Please return completed Application to:

Independent Care Health Plan (iCare)

Family Care Partnership Program
 c/o Network Development
 ATTN: Megan
 1555 RiverCenter Drive, Suite 206
 Milwaukee, WI 53212
 Fax: 414-231-1092
 Email: netdev@icare-wi.org